

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

## 1. PLACE OF DEATH:

County HowardCity or town Jessup, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Jessup, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Jessup  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)2. (a) If veteran, name war None

## 3. (a) FULL NAME

Harviana Bahn

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Eugene Bahn6. (c) If alive, give age 78 years7. Birth date of deceased (mo., day, yr.) Jan. 3, 18718. AGE: Years 75 Months 4 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Williamsburg, Penna.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name William Starbald13. Birthplace York Co. Penna.14. Maiden name Mary Mc Keever15. Birthplace York Co. Penna.16. Informant Mrs. Charles P. BaileyAddress Jessup, Md.17. Buried Date thereof May 16, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory London ParkLocation Frederick Ave. Belts Md.18. Funeral director Easton SonsAddress Ellicott City, Md.19. May 14 19 46 (Date rec'd by registrar)(Miss) E. Bird William

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1946 at 1:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1946 to May 13th 1946and that I last saw him alive on May 13th 1946Immediate cause of death Cerebral hemorrhagewith hemiplegiaDue to Hypertensive Cardisvascular disease

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. \_\_\_\_\_

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

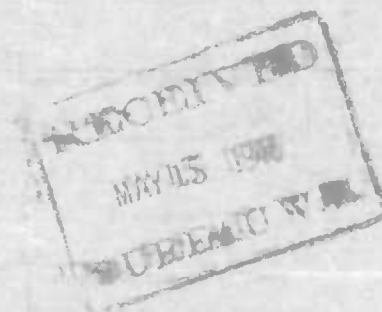
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Frank Shipley, M.D.Savage, Md.Date signed 5/14/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FILM No. I O 4 MAY 27 1946

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

Evidence for the change of age is shown on Film 104 5/17/46

## CERTIFICATE OF DEATH (31-2)

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

(c) City or town

(d) Street No.

(e) Citizen of foreign country?

If yes, name country

## 3 (a) FULL NAME

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual Occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date died by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04905

Reg. Dist. No. 194

## 1. PLACE OF DEATH:

County HOWARDCity or town CLARKSVILLE RURAL  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 YEARS

Hospital, institution, or street address where death occurred:

WALNUT GROVE FARM - SHEPHERD'S LANEHow long in hospital or institution?       

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HOWARDCity or town CLARKSVILLE RURAL  
(If outside city or town limits, write RURAL and give nearest town)Street No. WALNUT GROVE FARM - SHEPHERD'S LANE  
(If rural, give LOCATION)2(a) If veteran, name war       

## 3. (a) FULL NAME

LILLIE ELIZABETH JOHNSON

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race COLORED 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife JOHN THOMAS JOHNSON6. (c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) SEPT. 27, 18998. AGE: Years 46 Months 6 Days 25 If less than one day        hrs.        min.9. Birthplace CLARKSVILLE, HOWARD CO., MD.  
(Town, county, and state)10. Usual occupation HOUSEWIFE11. Industry or business HOME12. Name WALTER DAVIS13. Birthplace HOWARD COUNTY, MD.14. Maiden name BERTIE BROWN15. Birthplace HOWARD COUNTY, MD.16. Informant JOHN JOHNSONAddress CLARKSVILLE, MD.17. BURIAL Date thereof 5/5/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HOPKINS CHAPELLocation HIGHLAND, MD.18. Funeral director ROBERT SNOWDENAddress ROCKVILLE, MD.19. 5/3 46 Maria G. Whitaker  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 2 19 46 at 11 40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEB. 15 19 46 to MAY 2 19 46and that I last saw et alive on APRIL 30 19 46Immediate cause of death CACHEXIA DURATION 1 MONTHDue to CARCINOMA HEAD OF PANCREAS WITH METASTASES } 1 YEARDue to       Other conditions       

(Include pregnancy within 3 months of death)

Major findings of operations CARCINOMA HEAD OF PANCREAS  
C METASTASES TO LIVER Date of op. 2-25-46Autopsy results       

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide        Date of       Where did injury occur?        (City or town) (County) (State)Injured at home, farm, industry, public place (where?)       Means of injury        Injured at work?       23. SIGNATURE Charles S. Whitaker M.D. M. D. or otherAddress CLARKSVILLE Date signed 5/2/46

RECEIVED  
MAY 8 1946  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

04906

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

## 1. PLACE OF DEATH:

County NewardCity or town Highland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County NewardCity or town Highland  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Stafford Warwick Keegin

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Helen Jackson Keegin7. Birth date of deceased (mo., day, yr.) October 24, 1901 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 44 Months 6 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Washington DC  
(Town, county, and state)10. Usual occupation Attorney

11. Industry or business

12. Name Wm C Keegin13. Birthplace Wash. D.C.14. Maiden name Mary Seitz15. Birthplace Wash. D.C.16. Informant Helen J KeeginAddress Highland Md.17. Burial Date thereof 5-21-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St LouisLocation Locksville Md.18. Funeral director J.C. KnapptonAddress Elliot City Md.19. 5-21 46 Maria G. Whitaker  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/20 19 46 at 1-30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/20 19 46 to 5/20 19 46 and that I last saw him alive on no date 19 \_\_\_\_\_Immediate cause of death Coronary Thrombosis

## DURATION

15 months

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George E. Burdick M.D.  
Acting Deputy Medical Examiner Howard Co.  
Address Elliot City Md. Date signed 5/20/46

21020

RECEIVED

44

RECEIVED

*Reorganized*

*may 1*

ANTHONY LEGER

RECEIVED

MAY 29 1946

BUREAU V.B.

*Anthony Leeger*

44

12-2



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

C4907

Reg. Dist. No. 193

## 1. PLACE OF DEATH:

County HowardCity or town Bethon  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Bethon  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ernest Mercer

## 3. (b) Social Security Number

?

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife unknown7. Birth date of deceased (mo., day, yr.) ?  
6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 58 Months - Days - If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name unknown13. Birthplace "14. Maiden name Elyz. Spurr15. Birthplace md.16. Informant George KnauffAddress Edgemoor City md.17. Burial Date thereof 6-3-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory WesternLocation Baltimore md.18. Funeral director F.C. HigginbottomAddress Edgemoor City md.19. June 1- 19 46 C. Carl Mercer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 19 46, at \_\_\_\_\_ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 46 to May 31 19 46 and that I last saw him alive on May 31 19 46.Immediate cause of death Pulmonary Infarction

DURATION

3 da.Due to ?

Due to \_\_\_\_\_

Other conditions Angina Pectoris 3 daChro. Myocarditis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. Stanley Grabill M. D. or other \_\_\_\_\_Address MDAing, Md Date signed 6/1/46



RECEIVED  
JUN 8 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town near Elkhridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town 1608 Rolling Road  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Edgar Gilpin Miller

## 3. (b) Social Security Number

214-20-7349

4. Sex

M

5. Color of face

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife My wife7. Birth date of deceased (mo., day, yr.) Feb. 4, 1914

8. AGE:

Years

Months

Days

If less than one day

32318

hrs.

min.

9. Birthplace Easton Pa  
(Town, county, and state)10. Usual occupation Medical doctor

11. Industry or business

12. Name Norman A Miller13. Birthplace Pa14. Maiden name Susan Gilpin15. Birthplace Pa16. Informant Dr. H. SchullingerAddress Easton Pa.17. Removal Date thereof 5-23-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Easton PaLocation Easton Pa.18. Funeral director W. C. WignallAddress Elkridge City Md.19. May 23 19 46 John B. Loughan  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/22 19 46 at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/22 19 46 to 5/22 19 46and that I last saw him 100 alive on no date 19 46

Immediate cause of death

Compound fracture of skull  
in frontal region

DURATION

instant

Due to .....

Due to .....

Other conditions multiple fractures instant

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/22/46Where did injury occur? near Elkhridge Howard Md  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Highway Route #1Means of injury auto accident Injured at work? no23. SIGNATURE George E. Buehler M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

M. D. or other

Address Elkridge City Md. Date signed 5/22/46

RECEIVED  
MAY 25 1946  
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 14900

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

81

-

27

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

M. II or other

Address

Date signed

RECEIVED

MAY 21 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04910

Reg. Dist. No. 74 193

## 1. PLACE OF DEATH:

County HowardCity or town Gallop Springs  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CarrollCity or town Keok  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

4. Sex M5. Color or race W6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Chas. D. Nott

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 18808. AGE: Years 45 Months 4 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Md.  
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name John Nott13. Birthplace Md.14. Maiden name Bessie Fowler15. Birthplace Md.16. Informant Mrs. Chas. D. NottAddress Mt Airy, Md.17. Burial Date thereof May 6, 1946  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Freemant CemeteryLocation Libertytown, Md.18. Funeral director C. Henry EwenAddress Shadesville, Md.19. May 5 1946 C. Henry Ewen  
(Date rec'd by registrar) Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 1946, at 8<sup>25</sup> A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/3 1946, to 5/3 1946and that I last saw him alive on no date 1946Immediate cause of death Coronary Thrombosis

DURATION

instant

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

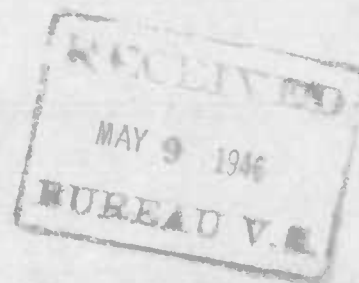
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE George E. Bristow m. S

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other

Address Elkhart City, Md Date signed 5/3/46





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/14

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Howard  
 City or town..... Elkhridge - 27, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 3 yrs.  
 Hospital, institution, or street address where death occurred.....  
 Balto. Wash. Blvd. - near Orsey  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Howard  
 City or town..... Elkhridge - 27, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Balto. Wash. Blvd.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war.....

## 3. (a) FULL NAME

Lina R. Schlossstein

## 3. (b) Social Security Number

4. Sex..... Female  
 5. Color or race..... W.  
 6. (a) Single, married, widowed, or divorced..... Widowed.  
 6. (b) Name of husband or wife..... Fredk J. Schlossstein  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... April 6<sup>th</sup> 1870  
 8. AGE: Years..... 76 Months..... 1 Days..... 0 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore City  
 (Town, county, and state)

10. Usual occupation..... Huf -

11. Industry or business.....

12. Name..... Geo. Raiber  
 13. Birthplace..... Germany

14. Maiden name..... Unknown.  
 15. Birthplace..... Germany

16. Informant..... Mrs. S. W. Atfield

Address..... Elkhridge - 27, Md.  
 Burial

17. (Burial, cremation, or removal. Which?) Date thereof..... 5/8/46  
 (month) (day) (year)

Cemetery or crematory..... Balto. Cem.

Location..... Balto. City, Md.

18. Funeral director..... Wm J. Dickner & Sons

Address..... Balto., Md.

19. 5-7 - 19 46  
 (Date rec'd by registrar) Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 6<sup>th</sup> 19 46, at 8:30 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6<sup>th</sup> 19 45 to May 6<sup>th</sup> 19 46  
 and that I last saw him alive on May 5<sup>th</sup> 19 46

Immediate cause of death..... Cerebral Hemorrhage

Due to..... Hypertension

Due to..... Arterio-sclerosis -

Other conditions..... Chr. Nephritis -

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Frank Shirley M.D.

Address..... Savage, Md. Date signed..... 5/8/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04912

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard  
City or town White Pl, Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months  
Hospital, institution, or street address where death occurred: \_\_\_\_\_  
How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard  
City or town Ellicott City, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME

Elizabeth Rebecca Queen (SMITH)

3. (b) Social Security Number

4. Sex F. 5. Color or race C. 6.(a) Single, married, widowed, or divorced Widowed, Married

6.(b) Name of husband or wife Deceased

7. Birth date of deceased (mo., day, yr.) UNKNOWN 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 45? Months ? Days P If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ellicott City, Howard Co, Md.  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business NONE

12. Name William Jones

13. Birthplace Baltimore Md.

14. Maiden name Olga Nelson

15. Birthplace ?

16. Informant Thomas Jones

Address Ellicott City Md

17. Burial Burial Date thereof 5-31-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Locust Chapel

Location Atholton, Maryland

18. Funeral director F.C. Higginbotham

Address Ellicott City, Md

19. May 30, 19 46 John B. Loughran  
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 May 19 46 at 8<sup>30</sup> A. M.

21. I CERTIFY that death occurred on the date (above stated); that I attended deceased from 28 May 19 46 to 29 May 19 46 and that I last saw him alive on 28 May 19 46

Immediate cause of death Cerebral Hemorrhage DURATION 18 hours

Due to hypertension P

Due to \_\_\_\_\_

Other conditions UNKNOWN

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William F. Jassaway, M.D.

Address Ellicott City, Md Date signed 5-29-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 5 1946

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04913

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. St. Paul St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

## 3.(b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced married8.(b) Name of husband or wife Bertie K. Stevens

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 19888. AGE: Years 58 Months - Days - If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Frederick Co. Maryland  
(Town, county, and state)10. Usual occupation STONE MASON

11. Industry or business

12. Name UNKNOWN13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Leslie StevensAddress Ellicott City Md.17. Burial Date thereof 5-28-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Ellicott City Md.18. Funeral director F.C. NigubathamAddress Ellicott City Md.19. May 28 19 46 John B. Longhman  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 25 19 46 at 7<sup>30</sup> A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/25 19 46 to 5/25 19 46 and that I last saw him alive on no date 19 \_\_\_\_\_

Immediate cause of death

Coronary Thrombosis

DURATION

20 min.

One to

One to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Burdette  
Acting Deputy Medical Examiner Howard Co.  
Address Ellicott City Md. Date signed 5/27/46

RECEIVED

MAY 29 1946

BUREAU V S



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

04914 192  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County HowardCity or town West Friendship  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town West Friendship  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John W Thompson

## 3. (b) Social Security Number

?

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Estelle B Thompson7. Birth date of deceased (mo., day, yr.) Aug. 18, 1886 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 59 Months 8 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Robert V Thompson13. Birthplace md14. Maiden name Martha Cunnell15. Birthplace md16. Informant Mrs. E. B. Thompson  
Address West Friendship Md17. Burial Date thereof 5-14-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory mt ViewLocation Alpha Md18. Funeral director St. V. S. McWhorterAddress Edmont City Md19. May 4 19 46 Alice W. Webb  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 5/2 19 46, at 1-15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 2 19 46 to May 2 19 46  
and that I last saw him/her alive on 5/2 19 46

Immediate cause of death

Myelogenous Leukemia

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. A. Barnes M.D. M. D. or otherAddress Sykesville Md Date signed 5/2/46

RECEIVED

MAY 7 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County HowardCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. Goddard Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ephraim W Walker

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife

Ide V Walker

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Apr. 24, 1864

8. AGE:

Years

Months

Days

If less than one day

82026

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Frank Walker

13. Birthplace

md

MOTHER

14. Maiden name

Harratt Brown

15. Birthplace

md

16. Informant

Mrs. Nancy Harrison

Address

Ellicott City md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5-23-46

(month) (day) (year)

Cemetery or crematory

Davidson

Location

Glenside md

18. Funeral director

J.C. Myerbach

Address

Ellicott City md

19. May 22 19 46

(Date rec'd by registrar)

John B. Loughan

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 46 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/2019 46 to5/2019 46

and that I last saw him alive on

5/2019 46

Immediate cause of death

Carcinoma of sigmoid  
Colon

DURATION

4 months

Due to

Due to

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Burdette

Address

Ellicott City, Md.

Date signed

5/21/46

RECEIVED

MAY 24 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 04916 191

## 1. PLACE OF DEATH:

County Howard

City or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 114 Frederick Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

George Edward Wheatley

## 3. (b) Social Security Number

4. Sex

M

5. Color of race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary V Wheatley

7. Birth date of deceased (mo., day, yr.)

March 18, 1865

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

81

1

16

hrs.

min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Jonathan Wheatley

13. Birthplace

Md.

MOTHER

14. Maiden name

Margaret Burgess

15. Birthplace

Md.

16. Informant

Mrs John W. Schant

Address

Ellicott City Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

5-7-46  
(month) (day) (year)

Cemetery or crematory

Mt View

Location

Alpha Md

18. Funeral director

F. C. DeGuzman

Address

Ellicott City Md

19.

(Date rec'd by registrar)

May 6, 1946

John B. Lushman

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1946, at 7:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1946, to May 4, 1946

and that I last saw him alive on May 4, 1946

Immediate cause of death

Atherosclerotic cardiovascular disease

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Leon G. Kalkman, M.D.

M. D. or other

Address Ellicott City Md Date signed 5/4/46

412

RECEIVED  
MAY 8 1946  
BUREAU OF

WAS CONTAIN